

**PATIENT INFORMATION**

PATIENT'S NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ SEX: M F BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ If Patient is a Minor, give Parent's or Guardian's Name \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

Who May We Thank for Referring You to our Office? \_\_\_\_\_ Reason for this Visit \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

RESIDENCE Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

MAILING ADDRESS Street \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

HOW LONG AT THIS ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

PREVIOUS ADDRESS (if less than 3 yrs.) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How Long \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

**RESPONSIBLE PARTY'S SPOUSE**NAME \_\_\_\_\_  
LAST FIRST MIDDLEEMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
NO. YEARS EMPLOYED

SOC. SEC. # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_

WORK PH. \_\_\_\_\_ E-MAIL \_\_\_\_\_

**EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE \_\_\_\_\_

HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_

WORH PH. \_\_\_\_\_

**DENTAL INSURANCE INFORMATION (Primary Carrier)**

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

**If you have double dental insurance coverage, complete this for the second coverage.**

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

***It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.***

DENTAL HISTORY		MEDICAL HISTORY	
	YES	NO	
HOW LONG SINCE you have seen a dentist?			Do you have any CURRENT HEALTH PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO
Last COMPLETE Dental Exam, Date:			Are you under a PHYSICIAN'S CARE now? For What? <input type="checkbox"/> YES <input type="checkbox"/> NO
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)			Are you taking medication for OSTEOPOROSIS? Which one? <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you having PROBLEMS now? <input type="checkbox"/> YES <input type="checkbox"/> NO			What MEDICATIONS are you currently taking? (List on reverse)
Please list:			Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is your present dental health POOR? <input type="checkbox"/> YES <input type="checkbox"/> NO			Are you PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you wear DENTURES? (Partials or Full) <input type="checkbox"/> YES <input type="checkbox"/> NO			Do you use cigars/cigarettes, pipe or chewing tobacco? (circle) <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you UNHAPPY with your dentures? <input type="checkbox"/> YES <input type="checkbox"/> NO			<b>PLEASE YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:</b>
Would you like to know more about PERMANENT REPLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			AIDS/HIV Pos. <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you APPREHENSIVE about dental treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO			Anaphylaxis <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had any PERIODONTAL (GUM) treatments? <input type="checkbox"/> YES <input type="checkbox"/> NO			Fainting <input type="checkbox"/> YES <input type="checkbox"/> NO
Do your gums BLEED, or feel TENDER or IRRITATED? <input type="checkbox"/> YES <input type="checkbox"/> NO			Food allergies <input type="checkbox"/> YES <input type="checkbox"/> NO
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle) <input type="checkbox"/> YES <input type="checkbox"/> NO			Glaucoma <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you UNHAPPY with the APPEARANCE of your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO			Arthritis (Rheumatism) <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you aware of GRINDING or CLENCHING your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO			Headaches <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have HEADACHES, EARACHES, or NECK PAINS? <input type="checkbox"/> YES <input type="checkbox"/> NO			Heart murmur <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you worn BRACES on your teeth (ORTHODONTICS)? <input type="checkbox"/> YES <input type="checkbox"/> NO			Heart problems (please describe) <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have DISCOLORED teeth that bother you? <input type="checkbox"/> YES <input type="checkbox"/> NO			Shingles <input type="checkbox"/> YES <input type="checkbox"/> NO
Would you like your smile to LOOK BETTER or DIFFERENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			Shortness of breath <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you REGULARLY use DENTAL FLOSS? <input type="checkbox"/> YES <input type="checkbox"/> NO			Skin rash <input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Previous Dentist?			Spina Bifida <input type="checkbox"/> YES <input type="checkbox"/> NO
City: _____ State: _____			Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO
How do you feel about your teeth?			Surgical implant <input type="checkbox"/> YES <input type="checkbox"/> NO
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.			Swelling of feet or ankles <input type="checkbox"/> YES <input type="checkbox"/> NO
FEAR of pain # _____ LACK of concern # _____			Thyroid disease or malfunction <input type="checkbox"/> YES <input type="checkbox"/> NO
COST of treatment # _____ MISSING work time # _____			Tobacco habit <input type="checkbox"/> YES <input type="checkbox"/> NO
			Tonsillitis <input type="checkbox"/> YES <input type="checkbox"/> NO
			Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO
			Ulcer/Colitis <input type="checkbox"/> YES <input type="checkbox"/> NO
			Venereal disease <input type="checkbox"/> YES <input type="checkbox"/> NO
			<b>ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?</b>
			Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.)
			Nitrous Oxide Codeine Penicillin
			Are you aware of being allergic to any other medications or substances?
			If yes, list:
			<i>Is there any other Medical or Dental information that you feel I should know about?</i>
			FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_ DENTIST Signature \_\_\_\_\_